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Multiple-family therapy: Forever promising? Commentary on Gelin et al. (2018) and Cook-Darzens et al. (2018) - The evidence base for Multiple Family Therapy in psychiatric and non-psychiatric conditions: a review (parts 1 and 2).

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Multiple-family therapy: Forever promising? Commentary on Gelin et al. (2018) and Cook-Darzens et al. (2018) - The evidence base for Multiple Family Therapy in psychiatric and non-psychiatric conditions: a review (parts 1 and 2).

Are Multiple Family Therapy (MFT) groups worth the effort? This is a salient question for busy clinicians and services considering how best to utilise their resources. Across their two papers, Gelin et al. (2018) and Cook-Darzens et al. (2018) provide a welcome overview of the evidence base for MFT across a wide range of psychiatric disorders and clinical contexts, suggesting that family therapists and their colleagues should indeed make the effort to deliver MFT.

The authors have provided a narrative review of the literature, which as they acknowledge is not exhaustive. We note that some important papers have been missed, including on caregiver group psychoeducation for bipolar disorder (Reinares et al, 2008) and group cognitive-behavioural family treatment for childhood OCD (Barrett et al, 2004), suggesting that the search strategy could have been more thorough. Further, the tables provide very little information about the studies and reviews on which the two papers are based. The authors could also have been more critical in their appraisal of the literature. There is a need for future reviews of the MFT literature to be systematic, to improve both the search strategy and consider the risk of bias within studies.

On the positive side, one of the most valuable aspects of the two papers is the attention paid to process issues. Findings from studies such as that by Hellemans et al. (2011) or Lemmens

et al. (2009a) suggest that a unique aspect of MFT is the interaction between group participants from different families, which is likely to be a key therapeutic ingredient in the treatment. Thus, the centrality of the professional therapist's role within MFT may be somewhat reduced as compared with single family therapy. Meanwhile, the position of families in MFT lies somewhere between the one in peer support groups and single family therapy. Indeed, MFT provides a unique context in which concepts and practice from family therapy can be combined with the broader trend in healthcare towards involving those with lived experience of physical and mental health conditions in the provision of treatment. Some authors (Glynn et al., 2006; Price-Robertson et al., 2017) have already stated that the non-pathologising stance, the use of a collaborative approach, the inclusion of mutual self-help and peer support in MFT makes it consistent with a relational approach to recovery that has family life at its heart. In addition, epistemic trust – that is, the ability to consider new knowledge from another person as trustworthy, generalizable, and relevant to the self (Fonagy & Allison, 2014) - may be more likely to develop when the person delivering the message is seen as credible by virtue of their lived experience. Future research should investigate how these issues might contribute to change in MFT. In the meantime, those involved in delivering MFT should think carefully about ways to maximise the therapeutic impact of those with lived experience in the structure, process and delivery of groups.

The two review papers provide evidence that MFT can be an effective intervention for a range of conditions. The authors note that MFT has most often been studied as an adjunctive treatment, and evaluated in non-randomised study designs, which limits how confident we can be about the efficacy of MFT as a stand-alone intervention. However, current evidence (Cuijpers et al., 2011) indicates that combining different treatments is more beneficial than

single interventions in serious psychiatric conditions, which is the target population of most MFT interventions. Indeed, we have good-quality evidence from randomised controlled trials that MFT leads to improved treatment outcomes as an adjunctive treatment in different psychiatric disorders such as adolescent eating disorders (Eisler et al., 2016), unipolar and bipolar depression (Lemmens et al, 2009b; Reinares et al, 2008) and schizophrenia (Bradley et al., 2006; Dyck et al, 2000).

Is MFT cost-effective? As discussed by Cook-Darzens et al. (2018), the assessment of cost-effectiveness becomes complicated when taking into account the sometimes increased use of mental health services by families who attend MFT. Indeed, MFT can increase the uptake of additional individual or family therapy, which may be regarded as a positive rather than a negative outcome. To date, little attention has been paid to the possible long-term beneficial and preventive effects of MFT on 'healthy' family members, such as children, siblings and partners. Recent evidence shows that MFT helps different family members in different ways (Salaminiou et al., 2017), and that individual viewpoints may converge to a more realistic, shared perspective (Depestele et al. 2017). However, thus far most MFT studies have focused on decreasing negative outcomes such as psychiatric symptoms and family burden, and have paid less attention to other ways in which MFT might 'add value' through improved relationships and mental health. Economic modelling of long-term health care costs, including those of 'healthy' family members, should be built in to future MFT trials.

The early 'hype' around MFT raised the hope that it might be an intervention that reaches the parts other therapies cannot reach (Schmidt and Asen, 2005). MFT research to date certainly shows that it has promise as an adjunctive treatment, and its distinctive format contains some unique therapeutic aspects. However, as suggested by the authors of the two review papers,

further research comparing MFT to other treatments is needed in order to build the evidence base for its effectiveness, whilst also illuminating its mechanisms of change. Without such comparisons to other active treatments, we cannot be sure that MFT is able to deliver improved outcomes over-and-above what other adjunctive interventions would provide. Stronger evidence of improved outcomes and cost-effectiveness would make the case for MFT truly compelling.

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